

**MEDICAL REPORT ON APPLICANT FOR CERTIFICATION TO PROVIDE CARE
FOR CHILDREN OR ADULTS WITH DISABILITIES**

For use of this form, see AR 608-75; the proponent agency is OACSIM.

NAME	DATE (YYYYMMDD)
FOR EXAMINING PHYSICIAN	
<p>Application is being made to obtain certification to care for children or adults with disabilities in their homes. We need to know if applicant has any health problems and the extent and significance of such problems insofar as they may affect applicant's ability to provide care to unrelated children or adults. This information is for confidential use.</p>	
CHECK APPROPRIATE BOXES AND EXPLAIN "NO" ANSWERS IN SPACE BELOW	
<p>1. IS THE APPLICANT FREE FROM ACUTE OR CHRONIC DISEASE THAT MIGHT AFFECT THE HEALTH OR DEVELOPMENT OF CHILDREN OR ADULTS UNDER CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>2. IN YOUR OPINION, IS THE APPLICANT FREE FROM ANY NERVOUS OR EMOTIONAL DISORDER THAT WOULD AFFECT THE WELL BEING OF THE INDIVIDUALS CARED FOR? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>3. DO YOU BELIEVE THE APPLICANT IS PHYSICALLY AND EMOTIONALLY CAPABLE OF CARING FOR MENTALLY RETARDED AND/OR PHYSICALLY DISABLED CHILDREN AND ADULTS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>A CHEST X-RAY OR TUBERCULIN TEST IS REQUIRED. IF EITHER TEST HAS BEEN DONE THROUGH YOUR OFFICE WITHIN THE LAST THREE MONTHS WOULD YOU INDICATE THE DATE GIVEN AND RESULT (POSITIVE, OR NEGATIVE)</p>	
CHEST X-RAY	TUBERCULIN TEST
DATE (YYYYMMDD)	RESULT
<p>TYPED NAME AND ADDRESS OF PHYSICIAN</p>	
<p>SIGNATURE</p>	
PERMISSION FOR RELEASE OF MEDICAL INFORMATION	
<p>I agree to the release of medical information to the ACS Respite Care Program.</p>	
SIGNATURE (Applicant)	DATE (YYYYMMDD)